Addressing the Need for Culturally and Linguistically Appropriate Health Information for Newly Arriving Refugee Populations

Project Report

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Project Background

According to the Office of Refugee Resettlement, HHS, 48,281 refugees arrived in the United States in FY07 from over sixty countries (Office of Refugee Resettlement 2007). Each refugee entering the United States has an initial health assessment once they arrive in their state of resettlement. The Refugee Health Information Network (http://www.rhin.org), a web based resource of over 1800 information materials pertinent to refugee health in 70 languages, is one source of health information for refugees and those who provide health services to them. RHIN is a partnership among John Scott and the Center for Public Service Communications, NLM, and state refugee health programs in Illinois, Massachusetts, Texas, California and Florida. This project was a collaboration with NLM's Specialized Information Services Division and RHIN.

The project proposal asked for an assessment of "the issue of how refugee health coordinators, and other health professionals who work with refugee and asylee clients, address problems associated with the need to find/develop linguistic and culturally appropriate materials for newly arriving refugees for which there is little or no written health information." This project was proposed in response to emails received by RHIN about where to find information for the newest refugee populations into the United States, in particular for refugees from Burma, Bhutan, Burundi and Iraq.

The initial deliverables for the project were to be a report of an interview-based study and an end-user survey instrument. Through discussions, the study became an information needs assessment based on an emailed assessment instrument and follow-up interviews.

Methodology

I began the project by doing a self-study of the refugee resettlement process and researching some of the issues associated with providing health care to refugees. I also learned about the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health, HHS, and the more general topic of health communication. Some of the tasks I did in this self study period included reading *The Spirit Catches You and You Fall Down* by Anne Fadiman and taking a web-based CE course from the Health Resources Services Administration, HHS, called "Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency."

I conducted a couple of informational interviews with librarians who are involved in the provision of refugee health information. Jackie Coughlan is a librarian at SUNY-IT and the developer of CulturedMed (http://culturedmed.sunyit.edu), a web site that provides annotated bibliographies on health beliefs and cultural backgrounds of new populations. Ellen Howard is the library director of Harborview Medical Center in Seattle and the creator of EthnoMed (http://ethnomed.org) which provides information on cross-cultural health and multilingual patient materials. Towards the end of the project, I spoke with Dr. Mary Alice Gillispie who, with community partnerships around the country, creates and distributes multilingual health information in a variety of multimedia formats at Healthy Roads Media (http://healthyroadsmedia.org).

In consultation with Gale Dutcher and Stacey Arnesen in SIS and John Scott, Executive Director of RHIN, I drafted a list of questions about the creation, provision and distribution of refugee health information. With the help of Alla Keselman in SIS, I used the broad list of questions to develop two information assessment tools—a written information request and follow-up interview questions. The tools were then sent out for comments to Coughlan, Howard, Ann O'Fallon, Refugee Health Coordinator in Minnesota and the chair of the Association of Refugee Health Coordinators, and Jennifer Cochran, the Massachusetts Refugee Health Coordinator.

The written information request was sent by RHIN to Ann O'Fallon for distribution at her discretion. Responses were collected by RHIN. In all, we received thirty-six responses to the information assessment. I conducted half hour phone interviews with

ten refugee health professionals and analyzed the responses of the information needs assessment and interviews.

The broad questions the project sought to answer were:

- How do those who serve new refugee populations find information about and for their clientele/patients?
- What are some preferred sources for such information?
- How are new refugee health information materials created and distributed?
- To what extent is existing refugee health information freely available and accessible?
- What are the current unmet information needs as related to refugee health?

As deliverables, the project leaders requested a summary of the findings of the information gathering and recommendations.

Refugee Health Background

The 1951 United Nations Refugee Convention determined certain parameters under which a person may be considered a refugee. In particular there must be a well-founded fear of persecution. People seeking refugee status must be granted such status, usually by the United Nations. Anyone coming into the United States with a refugee designation is doing so legally and has the opportunity after a year to begin the citizenship process.

Refugees are identified by the UN High Commissioner on Refugees and referred to the United States based on priorities and ceilings set annually by the President and implemented by the U. S. State Department. Before final approval is made to enter the United States, background checks and interviews are completed by the Department of Homeland Security.

The State Department, which contracts with voluntary resettlement agencies (called VOLAGs) to provide direct services for refugees for 30 days, notifies resettlement agencies and public health officials about incoming populations. The Office of Refugee Resettlement contracts with VOLAGs and states for services up to 60 months.

The Centers for Disease Control and VOLAGs notify state and local public health agencies when specific individuals arrive. The health agencies or contracted clinics conduct initial health screenings on every incoming refugee and initiate treatment for any active TB.

The voluntary resettlement agencies determine where to place new refugee populations. Although there are states, such as Minnesota and Georgia, that have become hubs in recent decades for resettlement, every state has some refugee resettlement.

Even states that receive small numbers of refugees may still have much diversity. For example, North Dakota had 204 new arrivals from ten different countries in FY07. Vermont had 147 arrivals from nine countries (Office of Refugee Resettlement 2007). Because priorities are set every year, states could see new populations regularly, perhaps with little advance notice.

Diversity among refugees from a particular country can also create a challenge. Consider Burma, the number one country from which refugees arrived in FY07. Over time, political turmoil in Burma has led to many refugees in the region. Refugees from Burma are coming directly from refugee camps which may have been their home for their whole lives and represent a variety of ethnicities. Burma, which borders India, China and Thailand, is a diverse country. Refugees "from Burma" could be ethnic Burmans, Karen or Chin. There are cultural, linguistic and religious differences among and within the many ethnic groups from Burma. One refugee health professional I spoke with who works with Karen refugees, for example, told me: "They have been persecuted by the Burmese, they don't speak the language, and it's almost a slap in the face to come here and be given Burmese language materials." Learning about the culture of Burma and having materials in the Burmese language may be helpful, but it would not be sufficient for serving these populations.

For those who serve multiple populations of refugees, such as the local public health agencies who provide initial health screenings, providing linguistically and culturally appropriate services can be a challenge. The Office of Minority Health requires that health care organizations that receive federal funds comply with 14 standards, referred to as the CLAS standards, related to culturally and linguistically appropriate services.

For example, the first standard states: "Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language" (U. S. Department of Health and Human Services, Office of Minority Health 2007).

Because of these standards and as part of their service contracts, clinics must provide interpreters. This can take some creativity and compromise, particularly for very new populations. Interpreting, especially in a sensitive, medical situation, is a skill. It's not as simple as pulling in a family member, which for many reasons is strongly discouraged. Some clinics, especially in larger areas or where there is an existing population, might have staff interpreters. Phone interpretation is commonly used as an alternative, but there are logistical complications with the lack of an in-person

interaction. Another potential alternative is coordinating among resettlement agencies and health agencies to share interpreter services.

Like interpretation, the translation of new materials is a complicated process, especially if done correctly. It's not as easy as taking an English language document and translating it into a 1000 different languages—cultural and linguistic differences must be taken into account. Ideally materials should be back-translated: English to other language back to English for quality control. This type of translation can be expensive and time-consuming.

Information Needs Assessment Results

Who are these professionals and where do they work?

Thirty-six respondents from fifteen states completed the assessment. There were several states with multiple responses, notably North Carolina, Massachusetts and Florida. We heard from five State Refugee Health Coordinators, sixteen clinicians who conduct initial health screenings, seven public health administrators who work at a variety of different agencies, five social workers/case managers, and three resettlement agency administrators.

Nineteen respondents (five refugee health coordinators, eleven clinicians, three administrators) work for state or local agencies. Ten work at a clinic or hospital. Four work at a community organization and three work for VOLAGs.

Respondents were asked if they were willing to be contacted for follow-up interviews. Ten interviews were conducted and interviewees were representative of the respondent pool in terms of geography and roles.

What populations are they serving?

In phone interviews, I asked refugee health professionals if they were currently working with any newly arriving populations. Most are, and most are seeing two or more new populations. Currently, the newest populations for most interviewees were from Burma, Iraq, Bhutan, and Burundi. According to the interviewees, many new populations come in waves. A typical response was that they had been seeing one or two populations for the last six months, are beginning to see another population, and have heard that another is coming.

How are new populations identified?

Depending on their role and work location, respondents learn about the arrival of new populations to their service area in a variety of ways. Local resettlement agencies are notified of new arrivals by their national VOLAG. State refugee health professionals typically receive notification from the Centers for Disease Control with the names, date of birth, gender, local resettlement agency, and contact information for any local family members of entering refugees. They may also receive notification from the resettlement

agencies themselves. Clinicians and clinic administrators are notified by state officials and/or resettlement agencies.

Of the respondents, most hear about new arrivals from resettlement agencies. Other avenues of hearing about the arrival of new populations include through community word-of-mouth, colleagues, and State Department notices.

How do they learn about the new population?

Most respondents attempt to learn about the culture and/or health beliefs of newly arriving populations, with very few exceptions. They use a variety of resources to do so; most respondents listed four or more. The most used are: internet searches, resettlement agencies, community members, specific websites, colleagues, and government agencies. Community sources include on-staff interpreters, community health workers, community centers, focus groups, community leaders and regular events such as monthly "Conversations in Culture." The most mentioned website was the Cultural Orientation Resource Center (http://www.cal.org/co/).

Do they provide health information to refugees?

Nearly all respondents provide refugee populations with health information on either a community or individual basis. Thirty-two (out of thirty-four) respondents provide health information to refugee populations, either directly or indirectly. Twenty-one provide information on an individual basis, three provide information at a community/group basis, and eight provide information to both groups and individuals. Two respondents, both refugee health professionals, do not provide health information to refugees.

They may provide information directly, for example in a clinic encounter, or indirectly, such as a State Refugee Health Coordinator who distributes information to affiliated clinics. The two most popular formats for the provision of health information are print or in person. Several respondents use media such as DVDs, CDs, or videos. Several also provide health information to a wider audience through TV or radio. One respondent uses web-based multimedia sources.

How do they get information for refugees?

The top sources of health information for refugees are state and local public health agencies (not necessarily their own), a general web search, RHIN, a paid translation service, Ethnomed (http://www.ethnomed.org), and Healthy Roads Media (http://healthyroadsmedia.org). International sources, particularly from New South Wales, Australia (http://www.mhcs.health.nsw.gov.au), are used by several respondents. Other web sites mentioned by more than one respondent are the US Committee for Refugees and Immigrants Healthy Living Toolkits (http://www.refugees.org), SPIRAL (http://www.library.tufts.edu/hsl/spiral/), the CDC (http://www.cdc.gov) and 24 Languages (http://library.med.utah.edu/24languages).

Are they involved in the creation of new materials?

In addition to obtaining materials from outside sources, approximately half of the respondents are involved in the creation of health materials. Of 33 respondents, 18 (55%) reported that their organization produces patient/consumer education materials. Of the 18, two are refugee health coordinators, nine were clinicians, six were administrators, and one is a social worker. This may take many forms including modifying existing materials, creating plain language English materials, paying for translation or in-house volunteer translation.

Respondents were asked whether the information their organizations create is publicly available and whether there were restrictions on their use. Ten respondents said their materials are publicly available. Two responded no. One respondent said there are restrictions on in-house created materials. Eight said there are not, and seven didn't know. Of those that didn't know, two are refugee health coordinators, four are clinicians, and one is an administrator.

Of 31 respondents, four reported that their organization contracts out the production of materials. Those four included two refugee health coordinators, one clinician, and one administrator. Three take steps to ensure that materials for which they contract are free of copyright restrictions. One does not. Two state refugee health coordinators reported that there are restrictions on the use of materials for which they have contracted. One clinician said there were not restrictions on the use of contracted-

for materials. One administrator did not know if there were restrictions on such materials.

Of thirty-two respondents, eighteen edit existing patient education materials in some ways. All six administrators reported editing existing materials.

How do they judge the appropriateness of materials?

When asked to what degree they felt they are successful in providing material that was linguistically and culturally appropriate, all respondents reported that they are either very or somewhat successful. About half feel they are very successful in providing information that was linguistically appropriate and about 40% reported being very successful in providing information that was culturally appropriate.

Of those who provide health information to refugees, the majority (19 out of 33) always assess the English literacy level of clients/patients. Six sometimes assess English literacy, six never do, and two responded N/A.

Respondents were asked: If you get health information for patients from outside sources, how do you judge its appropriateness for your clientele and its accuracy? Responses were varied and usually included doing one or more of the following: looking at the English translation, having an in-house interpreter or native speaker review the material, having other staff review, and using only reliable/approved sources. One respondent using criteria developed by a librarian in the NN/LM: Greater Midwest Region. Typical responses were: “read the English version and *hope* it’s correctly translated if I like it;” “it’s hard to tell—but if the website is from a government or college or a source equivalent, I am assuming it is accurate;” and “Pretty difficult to do, but we read the English versions to make sure we agree with the content before using a Karen document. We have an in-house Karen/Burmese/English translator who we ask to read the materials before giving them out.”

What are some issues with providing culturally and linguistically appropriate information?

In interviews, public health officials identified several issues with providing culturally and linguistically appropriate health information: lack of existing materials in

appropriate languages, the expense of buying or producing materials, and finding qualified interpreters and translators.

A major issue seems to be the literacy of many refugees in any language. Many cultures do not have an existing culture of using written language to convey information. This can be complicated by the issue of health literacy. These two interconnected issues create uncertainty among health professionals that existing and available health information materials will be read and understood.

There are mixed feelings about print. Some almost see no use for it with the populations they see. "I can not emphasize enough how little paper is used here because they just don't read," one administrator said. Others feel like they need to have something for patients to leave with because there is too much information to absorb in the time they have.

It's important to note that these are not necessarily continuing relationships. The clinicians see refugees two or three times, sometimes more to treat active TB. They are also seeing refugees in their first week or two in the United States, when new arrivals are overwhelmed just trying to understand the basics of being here. A clinician in New Mexico put the information-overload this way: "Not only are we picking at them, they have been fasting for tests, and here we are giving them all this information."

One issue faced particularly by clinicians is the lack of time to look for appropriate materials. A couple expressed a desire for more information sharing among health and information providers, so that time and money are not wasted in duplication of efforts.

As public health officials make budgetary decisions, some of these issues become intertwined. When money is tight, as one state refugee health coordinator told me, "It's hard to justify the cost of translated materials when so few are literate in that language." As an experiment, another state coordinator had avian flu materials translated by volunteers; when the materials came back from a translation service (used as a quality assurance measure) they were completely changed. The tradeoff, then, is that there will be less use in the future of volunteers but fewer translated materials.

The variety of populations that individual states and local public health agencies need to accommodate can influence decisions about how to spend limited resources.

While some places have enough of one population or several populations with a common language, that is not the case for many. One official I spoke with sees fifteen or more ethnicities per year. At one time, she saw mostly Bosnian clients and hired a staff interpreter/translator for that population. "Since then," she told me, "we've just never had one population that we could do that for."

What are some current information needs?

Respondents were asked for a list of their current information needs as related to refugee health. Nine out of thirty-six respondents (27%) did not identify any current needs. Those that did reported a variety of needs. One public health administrator described her needs as follows: "more information on more topics in more refugee languages related to a broad range of issues." More specific needs include: more time and money to devote to finding and evaluating existing materials and to create and share new materials. Many noted that there is often little notice of incoming arrivals, and it is impossible to get materials for less common languages in enough time. There is also a desire for one central repository for materials. For the reasons, I have mentioned, nonprint materials are in demand. Some respondents mentioned specific languages (including Karen and Burmese, Arabic and Swahili) and topics for which they need information. Topics most mentioned were: diseases such as TB, malaria, and STDs; maternal health; health system orientation; and preventative care topics such as immunizations, home safety, food safety and personal hygiene.

Several of the people I talked to said their main issue is making sure people understand the need for primary care. A local public health administrator in Minnesota said, "They really need to get that medical home." A clinician in Massachusetts said the time when information is really needed is "as they build their relationship with their primary care provider."

Recommendations

In creating recommendations, I have tried to find ways to increase visibility of RHIN to users and creators of new materials. There are several listservs for refugee health and for culturally and linguistically appropriate services that RHIN could send notices to and professional groups that RHIN could go through to promote the site. This assessment was limited in scope to refugee health professionals. However because so many respondents mentioned the importance of primary care and getting that "medical home," RHIN could also consider expanding outreach efforts to local clinics and perhaps hospitals that see emergency room visits for routine or preventable ailments.

While a number of respondents listed one central repository of multilingual health information as one of their needs, that is probably not a realistic goal. RHIN can save searchers valuable time and avoid duplication of effort in a number of ways. RHIN could provide a site index to Google so that relevant searches map to RHIN; this would also allow RHIN to be included in the National Network of Libraries of Medicine's targeted search for multilingual consumer health information (http://nnlm.gov/outreach/consumer/multi.html). RHIN could include a list of trusted partners and document producers on its homepage. Doing so will show which heavily used sources, particularly trusted partners like EthnoMed and HealthyRoadsMedia, can be accessed by searching RHIN.

RHIN could also alert users to updates on the site through a blog or subscriber email. One interviewee said that if she gets a new population, she will search once in RHIN and if she can't find anything she won't go back. RSS feeds would allow a user to subscribe to a search and then receive notice of new search hits as they are posted to RHIN.

Finally, RHIN can take a leadership role and fill a need by helping to develop standards for quality translation. Agencies at all levels—federal, state and local—can encourage those in their spheres of influence to use RHIN and to submit new materials to RHIN. For example, funders of the creation of materials can stipulate in contracts that materials be made available through RHIN or another accessible venue. A closer collaboration among agencies may also act as a pipeline for what formats, languages and topics should have priority when developing new materials, as it will be clearer what

materials already exist and where and what new populations need to be accommodated.

Discussion

It's important to note that this was a small sample size, too small to make generalizations based on geography or job title. The selection of participants was not scientific. It was distributed by one person to one group of constituents who then were asked to send it to other interested parties. Due to time constraints, there was not time for extensive follow-up on some of the more interesting or confusing results.

There was one issue that remains an open question: What are the implications for not having appropriate materials for refugees? It was a question asked in follow-up interviews, but there were mixed responses, not all relevant. Some potential implications for not having health information materials identified by interviews were: higher use and cost of interpreter services; less information from health screening "sinking in"; and chance of refugees then becoming, as one administrator put it, "poor utilizers of health care services." These respondents may not be in a position necessarily to see long-term implications, as some do not have direct contact with refugees and those that do may only have short-term contact. This question deserves further study.

There were several pieces of information that came from the information needs assessment and from my background research that were surprising/interesting to me and perhaps to others. It is clear that the refugee health community is an interdependent population. For example, health agencies use resettlement agencies for cultural orientation; clinics and case managers depend on state agencies for health information materials. Clinics and agencies will use materials from other states as well. I am amazed at the diversity of populations that even rural states see and how quickly that can change from year to year. I am intrigued by the apparent disconnect between the desire for non-print materials and the lack of use of such materials. For example, ten respondents use Healthy Roads Media, which has multiple web-based formats, but only one person reported providing health information in web-based format. I was also interested in the lack of librarians, either medical or public, as an information source. Given the lack of time and the location of many of these professionals' work place, that may not be surprising but it does represent an area for outreach for librarians.

On a personal note, this project has benefited me greatly. In addition to getting a strong background in the refugee process and the provision of culturally and linguistically appropriate health information, I was able to gain experience working with health care professionals as information users and providers, I made important contacts in the library and public health communities, and I learned a lot about qualitative and quantitative research methods. Through talking to refugee health professionals, I gained confidence in my abilities to listen and gather a lot of information in a short period of time.

Appendix A: RHIN assessment

Refugee Health Information Assessment

Thank you for participating in this assessment. This assessment is a component of a project by the Refugee Health Information Network (www.rhin.org), which addresses the need for culturally and linguistically appropriate health information for newly arriving refugee populations. Your input will help us understand some of the challenges of providing such information. In this assessment, we are focusing specifically on newly arriving refugees for and about whom there is little or no written health information. Assessment responses, minus identifying details, may be used in reports by RHIN.

This project seeks to answer several questions:

- How do those who serve new refugee populations find information about and for their clientele/patients?
- What are some preferred sources for such information?
- How are new refugee health information materials created and distributed?
- To what extent is existing refugee health information freely available and accessible?
- What are the current unmet information needs as related to refugee health?

Feel free to send this assessment to other interested colleagues.

Please return responses by **May 15** to John Scott, Director, Refugee Health Information Network, via email, at jcscott@cpsc.com or, if you prefer, by traditional post to Center for Public Service Communications, 3221 North George Mason Drive, Arlington, VA 22207.

1) What is your profession? _____

2) Please categorize your institution:
____ Primary care clinic
____ Hospital
____ State or local public health agency
____ Community organization
____ Other:_____

3) In what role have you had contact with newly arriving refugee populations (if any):

4) In your experience, how have you found out that new populations are arriving?
____ Centers for Disease Control notification system
____ Local resettlement agency

____ Community word-of-mouth
____ News media
____ Colleagues
____ Visits to clinic by members of new population
____ Other: _____

5) When you become aware of a new refugee population, do you attempt to learn about the culture and/or health beliefs of the arriving population? _____YES _____NO (if no, skip to 7)

6) Where have you searched for information about the population (please rate, in order, top three)
____ Web search engine (Google, Ask.com. etc)
____ Colleague
____ Federal Government agency (explain) _____
____ Members of new population (explain) _____
____ Resettlement agency
____ State or local public health agency (explain) _____
____ Medical/Public Library (explain) _____
____ Website (specify):_____
____ Other source (explain): _____

7) Do you provide refugee populations with health information?
____ YES, on an individual basis _____YES, on a community/group basis _____NO (skip to 21)

8) In what formats do you provide health information (check all that apply)
____ Print
____ DVD/CD/videocassette
____ In-person information sessions or tours
____ Web video
____ Web audio
____ Mobile audio/video (iPod)
____ TV or radio
____ Other: _____

9) To what degree do you feel you are successful in providing health information to refugees that is:
Linguistically appropriate? _____Very _____Somewhat ____Not at all
Culturally appropriate? _____Very _____Somewhat ____Not at all

10) Do you assess the English literacy level of your clients/patients?
_____Always _____Sometimes _____Never _____N/A

11) Does your organization produce patient/consumer education materials?
_____YES _____NO (if no, skip to 14)

12) Are the materials you create publicly available (that is, free of copyright restrictions)?
_____YES _____NO
If yes, where? _____

13) Are there any restrictions on their use or on their reproduction?
_____YES _____NO _____DON'T KNOW

14) Does your organization contract out the production of patient education materials?
_____YES _____NO (if no, skip to 17)

15) Do you take steps to ensure that the materials for which you contract are copyright free?
_____YES _____NO
If yes, explain how? _____

16) Are there any restrictions on the reproduction and use of the materials for which you have contracted?
_____YES _____NO _____DON'T KNOW

17) Does your organization localize or otherwise edit or revise existing patient education materials?
_____YES _____NO

18) Where else are you getting health information to give to refugee populations? (check all that apply)
____ State or local public health agency
____ Technology assisted translation (e.g. HealthComm, Phraselator, Babelfish, FreeTranslation.com)
____ Paid translation service
____ Web search (Google, Yahoo, other search engine)
____ Refugee Health Information Network (RHIN)
____ EthnoMed
____ HealthyRoads Media
____ International sources
____ Commercial producer
____ Other web site:_____
____ Other source:_____

19) If you get health information for patients from outside sources, how do you judge its appropriateness for your clientele and its accuracy?

20) Please list your top three resources for culturally and linguistically appropriate health information:

21) What are your current unmet information needs as related to refugee health?

22) Please list sources you know of for culturally and/or linguistically appropriate health information for the following refugee populations:

Burmese:

Burundian:

Iraqi:

Bhutanese:

We would like to interview a small number of respondents for more detailed responses. Please provide contact information if are willing to be contacted for a follow-up interview:

Thank you! Questions related to this assessment can be directed to: John Scott, Director, Refugee Health Information Network at jcscott@cpsc.com.

Appendix B: Interview Questions

Kate W. Flewelling
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March 14, 2008
Interview questions

Thank you for agreeing to speak with me. I am an Associate Fellow at the National Library of Medicine, and I am working on a project addressing the need for culturally and linguistically appropriate health information for newly arriving refugee populations. Your input will help me understand some of the challenges of providing such information. In this interview, I'd like to focus specifically on newly arriving refugees for which there is little or no written health information. The interview should take less than an hour.

- Please describe your position, particularly in regards to your work with refugee and asylee clients.
- How are new populations identified and accommodated?
- Are you currently working with any newly arriving populations for whom there is little health information? If not, have you in the past?
- What are some of the issues you have had with providing culturally and linguistically appropriate health information to new populations of refugees? How have you addressed those issues?
- When faced with a new population, how do you go about getting information about the population? To give to the population?
- Are you involved in the creation of written health information for new refugee populations, either in house or through a contract relationship? If yes—
    - To what extent?
    - How is the creation funded?
    - How are the creators/translators chosen?
    - Are your materials copyrighted?
    - Are your materials freely available through the internet?
    - What in your estimate is the typical time turnaround for the creations of such materials?
- In your experience, what are the implications for not having materials for new populations?

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